Medicaid Information Bulletin

October 2001

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

Requesting a Medicaid publication?

Send a Publication Request Form.

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

01 - 92 Co-payment for Physician, Podiatry, and Outpatient Hospital Services

Effective November 1, 2001, many adult Medicaid clients will be required to make a $2.00 co-payment for office visits performed by a physician or podiatrist and for outpatient hospital services. Services include those performed in a Federally Qualified Health Center (FQHC). Both HMO and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. The amount of the client's co-payment will automatically be deducted from the claim reimbursement.

Co-Payment Message on Medicaid Card, by Client

First, you must verify whether the individual client has a co-payment for the type of service needed. The Medicaid Card tells you when the person has a co-pay and for what types of services. The card will have a message "Co-payment required" at the top when any client listed on the Medicaid Card has a co-pay. A specific co-pay message will be next to a client's name. Below is an example of how a name and message may appear:

> **NAME**
> Smith, John Q
> Co-payment required for pharmacy, physician, podiatry, and outpatient hospital services.

The co-pay message may vary by client and whether the client is in an HMO or is fee-for-service. If there is no message by a client's name, the client does not have a co-pay. A family may contain an adult with a co-pay and children who are exempt. So you must verify whether the individual patient has a co-pay for the type of service.

No Co-payment for Exempt Services

Some services are exempt from co-pay. It does not matter whether the client has a co-pay or not. Do not collect a co-pay for the following types of service:

1. Family planning services have NO co-pay.
2. Emergency services in a hospital emergency department have NO co-pay. However, non-emergency use of a hospital emergency department may require a co-pay. Refer to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 2 - 1, Co-payment Requirement: Outpatient Hospital and Non-emergency Use of a Hospital Emergency Department.
3. Lab and X-ray services, including both technical and professional components.
4. Anesthesia services.

Co-payment Amount

The co-payment for physician, podiatry, and outpatient hospital services is $2.00. Before you collect a co-pay, be sure the client has a co-pay and that the service requires a co-pay. Please give the client a receipt for the co-pay collected.

As a reminder, pharmacy service has a $1.00 co-pay. Non-emergency use of an Emergency Department has a $6.00 co-pay.

For more information on the co-payment requirement for specific types of services, refer to SECTION 2 of the appropriate Utah Medicaid Provider Manual:

- Physician Services, Chapter 1 - 5
- Podiatry Services, Chapter 1 - 3
- Hospital Services, Chapter 2 - 1
- Pharmacy Services, Chapter 1 - 8

If you do not collect a co-pay owed at the time of service, you may bill the client for the amount that should have been paid. Refer to the Utah Medicaid Provider Manual, SECTION 1, 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Co-payments. SECTION 1 is on-line at www.health.state.ut.us/medicaid/SECTION1.pdf .

Clients Exempt from Co-payments

The Medicaid card states whether an individual client has a co-pay. Just for your information, a client in one of the following groups is exempt.

- child under age 18.
- pregnant woman.
- covered by a third party, including Medicare.
- total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy Families (TANF) standard payment allowance, as determined by an eligibility worker.
- resident of a nursing home.
- covered by UMAP (Utah Medical Assistance Program)
- co-payment maximum out-of-pocket has been met.

Pregnant Woman Exempt from Co-Pay

Do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

Co-payment Maximums Per Client

The maximum out-of-pocket co-payment per client is $100 a year for medical services. The maximum for pharmacy services per client is $5 a month. There is no maximum on co-pays for non-emergency use of the Emergency Department.

When a client meets the maximum medical co-payment, as determined by Medicaid billing information, the following month the co-pay message will change or be dropped. The client may continue to have a co-pay for pharmacy and non-emergency use of the Emergency Department.

Clients Notified of Co-payment

Medicaid sent a letter with the October Medicaid cards to tell clients about the new co-payment rules. November will be the first month with the co-pay message for medical services. We will urge clients to keep receipts for their co-pays in case of delayed billings by providers or discrepancies.

Provider Manuals Updated

The new co-payment requirement is added to SECTION 1 of the Utah Medicaid Provider Manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3. View the update in the on-line version of SECTION 1, pages 24 - 24A:
www.health.state.ut.us/medicaid/SECTION1.pdf. The co-pay requirement is also added to the list of items to be verified on the Medicaid Identification Card. [SECTION 1, Chapter 5 - 1, page 18.]

The new co-payment policy is also added to SECTION 2 of the following Medicaid manuals:
- Physician Services, Chapter 1 - 5, on-line at www.health.state.ut.us/medicaid/physician.pdf
- Podiatric Services, Chapter 1 - 3
- Hospital Services, Chapter 2 - 1

Attached are pages to update provider manuals.

Frequently Asked Questions (FAQ)

As questions about the co-pay policy are raised, they will be posted, with the Medicaid response, on the Medicaid web site under "What's New":
www.health.state.ut.us/medicaid/html/whatsnew.html

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01 - 93 Women with Breast or Cervical Cancer May Qualify for Medicaid

The Breast and Cervical Cancer Prevention and Treatment Act allows states to provide full Medicaid benefits to qualified women in need of treatment for breast and cervical cancers, including precancerous conditions and early stage cancer. The Utah Cancer Control Program (UCCP)[1] will refer women for Medicaid coverage.

The woman must meet all of the following requirements:
1. Diagnosis after April 1, 2001, by ANY health care provider in Utah, of breast or cervical cancer which requires treatment, including precancerous conditions.
2. Under the age of 65.
3. No insurance to cover the treatment needed.
4. A U.S. citizen or qualified alien.
5. Income is at or below 250% of the Federal Poverty Level.

Annual Income Guidelines (7/1/01 through 9/30/02)

Family Size	**250% of Federal Poverty Level** [2]
1	$21,475
2	$29,025
3	$36,575
4	$44,125
5	$51,675
6	$59,225
7	$66,775
8	$74,325

Utah is one of six states approved to provide treatment assistance for qualified women. For more information, call the Utah Department of Health, Utah Cancer Control Program: (801) 538-6990 or (801) 538-6491. Please have the patient's complete name and telephone number(s).

Information concerning this new Medicaid program has been added to SECTION 1 of the Utah Medicaid Provider Manual, as a new Chapter 1 - 6, Women with Breast or Cervical Cancer. View the update in the on-line version of SECTION 1, page 6:

www.health.state.ut.us/medicaid/SECTION1.pdf

Information on the Emergency Services Program has moved to Chapter 13 - 8. See Bulletin 01-119, Emergency Services Program for Non-Citizens.

[1] Utah Cancer Control Program (UCCP) is funded by the Centers for Disease Control and Prevention (CDC), National Breast and Cervical Cancer Early Detection Program (NBCEDP).

[2] Federal Registry, Vol. 66, No. 33. ☐

01 - 94 How Does the HIPAA Privacy Rule Affect You?

Each time a patient sees a doctor, is admitted to a hospital, goes to a pharmacist or sends a claim to a health plan, a record is made of their confidential health information. The confidentiality of this health information has been a source of concern and interest to lawmakers, policymakers and the public at large. The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), released April 14, 2001, assures protection of individually identifiable health information. The rule includes patient rights, use of medical records, and privacy safeguards. Providers and health plans must comply with the rule by April 2003.

Consumer control over health information

Patients have significant new rights as to how their health information is used.

- Providers and health plans must give patients a clear, written explanation of how they can use, keep and disclose their health information.
- Patients must be able to see their records, get copies, and request amendments. Also, a history of most disclosures must be made accessible to patients.
- Patient authorization to disclose information must meet specific requirements. Patients have the right to request restrictions on the use and disclosure of information.
- Providers and health plans generally cannot condition treatment on a patient's agreement to disclose health information for non-routine uses.
- People have a right to complain to a provider or health plan, or to the Secretary of Health and Human Services, about violations of the Privacy Rule, including policies and procedures of the provider or health plan.

Restrictions on use and release of medical records

With few exceptions, an individual's health information can be used for health purposes only.

- Patient information can only be used or disclosed for the purposes of health care treatment, payment and operations. Health information cannot be used for purposes not related to health care.
- Disclosure of information must be limited to the minimum necessary for the purpose of the disclosure. However, this does not apply to the transfer of medical records for treatment purposes; health care providers need the full record to provide quality care.
- Non-routine disclosures, with patient authorization, must ensure the patient is truly informed and authorization is voluntary.

Security of personal health information

The Privacy Rule states privacy safeguards. Providers and health plans must:

- Adopt written privacy procedures which include who has access to protected information, how it will be used, and when the information would or would not be disclosed to others.
- Provide sufficient training to employees so they understand the new privacy protection process. An individual must be designated as the privacy officer. The officer is responsible to make sure privacy rules are followed.
- Establish a grievance process for patients to make inquiries or complaints about the privacy of their records.

To learn more about the privacy standards, visit www.aspe.hhs.gov/admnsimp. ☐

01 - 95 Retroactive Medicaid Coverage Period Shortened

Effective August 1, 2001, the retroactive coverage period for Medicaid is further limited. Coverage may still be for the three-month time period immediately preceding the date of application for medical services. However, coverage will begin on the calendar day which matches the day of the month in which the application was filed. Coverage in the third month before the application date will no longer go back to the first day of that month. Services prior to the retroactive date are not covered. So LOOK CAREFULLY at the start date on the Medicaid Identification Card. The start date may not be the first day of the month.

For example, a client applies on May 16 for Medicaid and asks for retroactive coverage for services in February. Retroactive Medicaid may be approved back to February 16. The February Medicaid Card will say "Eligible from - February 16, 2001 THRU February 28, 2001". Services prior to that date would not be covered.

Information in SECTION 1 of the Utah Medicaid Provider Manual, Chapter 1 - 3 Retroactive Medicaid, has been updated. View the update in the on-line version of SECTION 1, page 5.
www.health.state.ut.us/medicaid/SECTION1.pdf ☐

01 - 96 Diagnosis Must Agree with Procedure Code; Use of 'V' Codes

Effective January 1, 2002, claims must have a **diagnosis that fits the procedures completed, or they will be denied.** A diagnosis code in addition to the V code **must also be** on the claim form. Make sure that the diagnosis and procedure codes agree!

Here are two examples:

- V code V10, personal history of malignant neoplasm, or V10.3, – breast, should be accompanied by other ICD.9 codes indicating the differential diagnoses that led to a decision for CT scans of the brain and spine. Chosen ICD.9 codes should reflect symptoms and/or indications that led to the decision for extensive imaging, laboratory tests, and/or a procedure.

- When using V code V67, follow up examination, include the code related to the original surgery, injury, or fracture.

Procedures for Children

When the majority of procedures are basically related to a routine health visit and/or childhood immunizations, V codes related to routine child health examinations, such as V20, V20.0, V20.1, V20.2 will be accepted alone for payment. However, when the child also has a medical condition that requires additional procedures (such as x-rays, laboratory examinations, etc.), place on the claim the ICD.9-CM code which describes the differential diagnoses for the medical condition. The ICD.9 codes assist in explaining the diagnostic test.

Diagnosis and Procedure Incomplete, or Not in Agreement

Past claims reviewed using the clinical claims editor program show numerous instances where the diagnosis does not fit the procedures listed on the claim, or the claim is submitted with only a V-code for the diagnosis. Claims submitted with only a V code will not be paid, with the exception of child health exams. Claims submitted with a diagnosis which does not agree with the procedure completed will be denied. Here is an example: A claim for CT of the abdomen which is submitted with diagnoses of headache and myalgia will not be paid.

Medicaid must have an accurate record of the diagnosis and procedures on submitted claims to evaluate programs and payment trends, and have accurate records. Claim payment to providers is delayed when inaccurate diagnoses are submitted. Other insurance providers including Medicare are using editing programs that review procedure to diagnosis issues. If you have questions, call Medicaid Operations. Staff can assist with training and/or provide a list of procedure-to-diagnoses for a particular issue of concern.

SECTION 1 Updated

Information on diagnosis and procedure codes has been added to SECTION 1 of the Utah Medicaid Provider Manual, as a new Chapter 8 - 4, Diagnosis Must Agree with Procedure Code; Use of 'V' Codes. View the update in the on-line version of SECTION 1, page 30B.

www.health.state.ut.us/medicaid/SECTION1.pdf

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01 - 97 New Patient and Established Within Group Practice: Enforcement of Coding

Effective October 1, 2001, the CPT Manual definition of new and established patient coding will be fully supported by computer edits, including patient services provided within a group practice. The definition is in the Utah Medicaid Provider Manual, SECTION 1, Chapter 8 - 2 Classifying Patients as 'New' or 'Established'. It states that a new patient "is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the last three years." (Emphasis added) The same statement applies to an established patient who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the last three years.

System support is now in place to edit this coding requirement within group practices.

As a reminder, the CPT Manual definition clarifies that "in the instance where a physician is on call for or covering for another physician, the patient encounter will be classified as it would have been by the physician who is not available." Also, the distinction between new and established patient does not apply to patients presenting to the Emergency Department for emergency services. Medicaid considers the term "emergency department" to be a designated emergency unit of a licensed hospital. No other facility or location will qualify under Medicaid as an "emergency department." You can review SECTION 1, Chapter 8 - 2 on-line at www.health.state.ut.us/medicaid/SECTION1.pdf □

01 - 98 Tetanus Vaccine Shortage Prompts UDOH to Recommend Td Vaccine Delay Until 2002

As a nationwide shortage of tetanus-diphtheria (Td) vaccine continues, Aventis Pasteur MSD, the vaccine's sole manufacturer, has announced it will no longer ship to private physicians, according to public health officials at the Utah Department of Health (UDOH). In addition, the UDOH is recommending that Utahns who are not in the priority groups (listed below) delay receiving the Td vaccine until 2002. This affects vaccine availability only for those over seven years of age. The supply of tetanus and diphtheria vaccines (DTaP) for infants and preschoolers is not affected by the shortage.

A nationwide shortage of Td has resulted because Wyeth, another vaccine manufacturer, discontinued production in January 2001. As a result, Aventis Pasteur is now the sole remaining supplier of Td in the United States. It is expanding its manufacturing capability to meet national needs. However, approximately 11 months are required for vaccine production. It is not known how long the shortage of these products will last, but it is anticipated to last at least through the end of this year.

"This means the vaccine for those over seven years of age will only be available through hospitals and county health departments," says Linda Abel, UDOH Immunization Program Manager. "Vaccine for those under age seven will continue to be available through private physicians' offices as well as county health departments." The adult and adolescent vaccine will only be given to those who fall within the Centers for Disease Control and Prevention (CDC) recommendations.

The recommendations are prioritized in the following categories of individuals over the age of seven:

- Persons traveling to a country where the risk for diphtheria is high
- Persons requiring vaccination for preventing tetanus as part of wound management
- Persons who have received less than three doses of tetanus and diphtheria vaccines during their lifetime.
- Pregnant women who have not received a tetanus booster during the preceding 10 years

The CDC and the UDOH recommend deferring all routine adult and adolescent Td booster vaccinations until 2002, or until the shortage has been resolved. This is in accordance with new recommendations made May 25, 2001, by the CDC that "all routine Td boosters in adolescents and adults should be delayed until 2002."

Health care providers are asked to record the names of patients whose booster dose is delayed during the shortage. When Td supplies are restored, these patients should be notified to return to their health care provider for vaccination. A person needs to have a Td booster every ten years to be protected from tetanus and diphtheria (lock jaw).

The UDOH is notifying health providers throughout Utah of this change and informing physicians that they will need to write a referral for any high-risk patients who go to a hospital or health department for Td vaccination per the recommendations.

"The limited adult and adolescent vaccine supply requires the cooperation of everyone involved," Abel says. "We must make sure that maximum disease prevention is achieved with the limited vaccine available. We will continue to keep health providers and the public informed of developments."

For more information, contact Linda Abel: (801) 538-6905, e-mail "label@doh.state.ut.us". ☐

01 - 99 Medical Abortion Coverage: Mifepristone (Mifeprex or RU-486)

Medicaid will now cover medical abortions with the use of Mifepristone (Mifeprex or RU-486) with written authorization. Coverage will only be authorized based on the Hyde Amendment, which limits use of federal funds to abortions to terminate a pregnancy resulting from an act of rape or incest or when a woman suffers from a physical disorder, physical injury, or physical illness, including a life - endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. The provider must comply with current limitations and criteria for coverage of abortion, strict requirements established by the pharmaceutical company, and requirements specific to use of Mifepristone.

Policy concerning abortion is specified in the Utah Medicaid Provider Manual for Physician Services Chapter 3, LIMITATIONS, item R, and in Criteria #17A (Criteria for Medical and Surgical Procedures). Policy on use of Mifepristone (Mifeprex or RU-486) has been added to Chapter 3, LIMITATIONS, as a new item S. Former items S and T are renumbered to T and U, which was reserved for future use. Providers will find attached SECTION 2, pages 18B through 19B, to replace existing page 18B - 19. ☐

01 - 100 Brand Name Medically Necessary Prescriptions to Be Audited

As of July 1, 2001, the Medicaid Program Integrity Unit began to randomly audit prescriptions billed with the DAW indicator requesting brand name reimbursement. In order for the prescription to be covered by Medicaid, it must meet the requirements stated in both the Utah Medicaid Provider Manual for Physician Services [SECTION 2, Chapter 2, Covered Services, item 19 Generic Drugs], and the Utah Medicaid Provider Manual for Pharmacy Services [SECTION 2, Chapter 4 - 4, Brand Name Drugs and Override]. Briefly, policy states that the brand name must be medically necessary. The prescription must state "brand name medically necessary" in the physician's handwriting. For complete information, refer to the policy cited above. Use this bulletin for additional clarification.

If the prescription does not meet coverage requirements, brand name reimbursement is not covered, and Medicaid will retract the entire payment. Examples of prescriptions which are not acceptable as 'dispense as written' include those without the required order in the physician's handwriting, such as a telephone prescription; signature boxes; letters such as "DAW"; abbreviations such as "no sub"; preprinted information; and instructions from someone other than the physician. Tegretol is the only medication that may be filled without specifying brand name medically necessary.

"Spend-Up" Allowed for Covered Products

Patient preference does not constitute a medical necessity. When the brand name is a covered product, a patient may obtain the brand by paying the pharmacist the difference between the cost of the generic (MAC) product and the cost of the name brand (EAC). Example: There is both a name brand and a generic available based on the client's prescription for 90 tablets. The name brand costs $0.22; total cost of product is $19.80. The generic brand costs $0.04; total cost of product is $3.60. The client may choose the generic brand covered in full by Medicaid or choose to pay the difference between the cost of the two products. In this example, the difference in cost is $16.20.

Cost of the brand name product may be found from many sources including the Redbook, wholesaler's microfiche, for example. The same dispensing fee is paid by Medicaid, regardless of whether the patient chooses the name brand or the generic. The provider must bill with the NDC dispensed. Medicaid will then reimburse the drug at the generic level.

Non-Covered Products

If the brand name is not covered, and the client chooses the brand name drug, the client is responsible for the entire payment. For example, Valium® is not covered by Medicaid because the manufacturer does not participate in the rebate program. If the prescription is for Valium®, and the client chooses Valium over the generic product, the client must pay the entire cost.

Billing Client Not Permitted for Disallowed Payment

Providers are **not** allowed to bill the client when Medicaid retracts payment for noncompliance. Medicaid clients may not be billed for charges disallowed or recovered by the state. If a provider has a problem with a recovery initiated by the state, he or she may request administrative review through the administrative hearing process to have the state reevaluate the situation and justify the action taken. [Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 14 Administrative Review / Fair Hearing]

Training Offered

A provider may also request training regarding appropriate documentation from the Program Integrity Unit. Staff can train on-site to explain exactly what problems are found and how to avoid these. To request training, contact Lydia Woodall, Division of Health Care Financing, at 1-800-962-9651, then press #401.

SECTION 2 Updated

SECTION 2 of both the provider manuals for physicians and for pharmacy services has been updated to clarify policy on brand name drugs. Replacement pages are attached to update manuals. View the updates on-line:

Physician Manual, SECTION 2

www.health.state.ut.us/medicaid/physician.pdf

Chapter 2, Covered Services, item 19, Generic Drugs, page 8

Pharmacy Manual SECTION 2

www.health.state.ut.us/medicaid/pharmacy.pdf

Chapter 4 - 4, Brand Name Drugs and Override, pg. 16.

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01 - 101 Child Health Evaluation and Care Manual and Recommended Schedule (Appendix C) Updated

The Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services is updated as follows:

- Clarifications are added to SECTION 2, Chapters 2 - 2, Comprehensive History; 2 - 5, Appropriate Laboratory Tests; 2 - 6 Health Education; and 3 - 2 Dental Services.
- An Index has been added to assist in locating information.
- The periodicity schedule (Appendix C, CHEC Recommended Schedule) is revised for 2001. There are changes to the usual procedures and the addition of procedures for patients at risk: tuberculin test, cholesterol screening, STD screening, pelvic exam, and blood lead level.

The revised SECTION 2 and Recommended Schedule are on the Internet. Look for the link to the CHEC manual at:

www.health.state.ut.us/medicaid/section2list.pdf

In the updated manual, a page which states "Page updated July 2001" on the upper right of the page has a new correction or clarification. A vertical line in the left margin marks where text has changed. The Internet copy formerly at "www.health.state.ut.us/medicaid/chec2.pdf" has been removed as it is now out of date. If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC manual, or use the Publication Request Form. ☐

01 - 102 Hearing Aids Require Written Prior Authorization

Effective October 1, 2001, hearing aids require written prior authorization. The change from telephone to written authorization affects five chapters in SECTION 2 of the Utah Medicaid Provider Manual for Audiology Services. It also affects the prior authorization indicator on the Medical Supplies List, categories HEARING AIDS and HEARING AIDS REPAIRS (page 59). [This list is a special attachment for two provider manuals: Medical Supplies and Physician Services.] Page 59 is attached for medical suppliers so they can update the list.

Audiologists will find attached an updated SECTION 2 for their provider manuals. A page which states "Page updated October 2001" on the upper right has a correction. A vertical line in the left margin marks where text has changed. ☐

01 - 103 Infant Hearing Screening Code

Medicaid supports the nationally recommended strategy to have all infants receive a hearing screen. Use code V5008 for a hearing screening (otoacoustic test) for infants under one year of age.

This information has been added to the Utah Medicaid Provider Manual for Audiology Services, SECTION 2, Chapter 2 - 1, Examination and Assessment. The addition is included in the SECTION 2 update attached for audiologists. ☐

Electronic Copies of Medicaid Information Bulletins and Index

Medicaid Bulletins published since April 1997 are on the Internet. You can find the links to both the current and past bulletins at:
www.health.state.ut.us/medicaid/html/provider.html .

There is also an Index to Medicaid Information Bulletins on the Internet. The Index has two parts: an alphabetical list of articles by keywords and title and a chronological list of bulletins by date published. The Index is at:
www.health.state.ut.us/medicaid/IndexMIBs.pdf .

Utah Medicaid Provider Manuals on the Internet: Physician Services, Pharmacy, CHEC Services

Three provider manuals are available on the Internet. Our goal is to have all current manuals on the Medicaid web site. Go to the Medicaid Provider Guide web site at
www.health.state.ut.us/medicid/html/provider.html and choose the link to SECTION 2. This page, like all other Medicaid publications, requires Adobe Acrobat software installed on your personal computer. (The Medicaid web site has instructions on how to download this FREE software if your PC does not already have Acrobat installed.)

The SECTION 2 list of provider manuals has links to the manuals available on the Internet. We suggest that, when you find the manual you want, you set a "bookmark". For example, set a bookmark for the Physician Services Manual at
www.health.state.ut.us/medicaid/phystoc.pdf.

01 - 104 Tuberculosis Skin Testing: Tine Method No Longer Covered

Effective November 1, 2001, CPT code 86585, tine method of tuberculosis skin testing, is no longer covered by Medicaid. Instead, use the Mantoux method of tuberculosis skin testing (CPT code 86580). The Center for Disease Control and Prevention (CDC) recommends and supports the Mantoux method as the standard of practice for tuberculosis screening. The Tine method is considered low in both sensitivity and specificity; therefore, it will no longer be covered.

The Medical and Surgical Procedures List (CPT code list), a special attachment to the Utah Medicaid Provider Manual for Physician Services, is amended to add code 86585, tine method of tuberculosis skin testing, as a non-covered benefit, to page 44. This page will be reissued with the next revision of the CPT code list. To obtain a copy immediately, contact Medicaid Information or use the Publication Request Form. ☐

01 - 105 Chemotherapy Administration

When a visit to the physician's office is for administration of a medication or chemotherapy agent, only the J code for the medication and the administration code (96400-96549) will be paid. An office visit will not be paid. Effective November 1, 2001, when significant, additional service meeting the level of the evaluation and management (E&M) code is provided on the same date of service, the E&M code may be paid in addition to the J code and administration code. Use modifier 22 when the claim is submitted. Include the medical record documentation for staff review.

Physician Manual Updated

The information on chemotherapy is added to the Utah Medicaid Provider Manual for Physician Services SECTION 2, Chapter 2, COVERED SERVICES, as a new item 23 on page 8. Subsequent items, formerly 23 through 30, are renumbered as 24 through 31, which was reserved for future use. Providers will find attached SECTION 2, page 8 - 9, to update their manual. View the update for the Physician Manual, SECTION 2 at:

www.health.state.ut.us/medicaid/physician.pdf

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01 - 106 Drugs and Prior Approval: PA Required for Cancidas, Flolan; PA Requirement Removed for ASA/dipyridamole (Aggrenox)

Cancidas, Flolan

Two drugs or drug classes have been placed on prior approval by the DUR Board effective October 1, 2001:

Cancidas - antifungal.

Flolan - primary pulmonary hypertension.

Both require written prior authorization. The Drug Criteria and Limits List contains the complete criteria. Pharmacists and providers of physician services will find attached pages 1 - 2 and 5 - 6 to update their list. On pages dated October 2001, a vertical line in the left margin marks where text has changed.

ASA/dipyridamole (Aggrenox)

ASA/dipyridamole (Aggrenox) has been taken off prior approval. This drug is removed from page 21 of the Drug Criteria and Limits List, the Table of Contents and Index. An asterisk in the left margin marks where text was deleted. ☐

01 - 107 Pharmacy Claims: Electronic Override for Early Refills Discontinued

The electronic override program in the Point of Sale System for pharmacy claims will be discontinued on October 1, 2001. Policy previously in the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 4 - 7 Early Refills, has been rescinded.

This change is the result of a review of Medicaid pharmacy claims for January 1, 1999 to September 30, 2000. The review found 102 claims which were electronically overridden by pharmacists. The Medicaid Program Integrity Unit reviewed the claims using units, not days' supply, as the parameter. Of the 102 claims from nine different pharmacies, 52 would not have had an increase in the dosage. Records for the 52 prescriptions were requested from the pharmacies, and copies of the prescriptions were obtained from the prescribers. On review, the prescriptions did not validate medical necessity for the early refill. As a result of the error rate, the electronic override program will be discontinued.

Pharmacy Manual Updated

Policy and procedures in the Pharmacy Manual are revised to eliminate the Early Refill Edit Override (SECTION 2, Chapter 4 - 7, Early Refills, and the Point of Sale Instructions, page 3, item 3 - Early Refill Edit Override). Pharmacists will find pages attached to update their provider manuals. ☐

01 - 108 Wheelchairs Purchased by Medicaid

SECTION 2 of the Utah Medicaid Provider Manual for Medical Supplies, Chapter 2 - 9, Wheelchairs, has been corrected in three places.

1. Item A, Wheelchairs Purchased by Medicaid, (page 27) has been clarified. The clarification in the sentence below is underlined for emphasis.

   A. **Wheelchairs Purchased by Medicaid**

   Medicaid will pay for one wheelchair which is the most cost effective that satisfies the medical needs of the Medicaid client.

2. Item G, Customized Wheelchairs, sub-item 5, Reimbursement (page 30), sub-item c is corrected as stated below, and a new sub-item d is added. The existing sub-item d is renumbered as "e."

   c, Reimbursement is by HCPCS codes.

   d. Design fee for customized wheel chairs are reimbursed using the following codes:

   – Y0662, Pediatric design, fitting and assembly fee
   – Y0665, Adult design, fitting and assembly fee

   These two design codes have been added to the Medical Supplies List under WHEELCHAIR and WHEELCHAIR ACCESSORIES, on page 40, along with the billing codes for motorized wheelchairs.

3. Item M, Customized Wheelchair Billing (page 35A) is deleted. As stated above, the billing codes for customized wheelchairs are listed in item G, Customized Wheelchairs, sub-item 5, Reimbursement.

Medical Suppliers Manual Updated

Medical suppliers will find attached the replacement pages to update SECTION 2 of their manuals and the Medical Supplies List. Codes Y0661 - Y0676 for customized and motorized wheelchairs have been added to the list. Physicians who want an updated Medical Supplies List should contact Medicaid Information or use the Publication Request Form. ☐

01 - 109 Periodontics (Gingivectomy) May Be Billed with Prophylaxis

SECTION 2 of the Utah Medicaid Provider Manual for Dental Care Services, Chapter 1 - 10 Periodontics has been corrected. The correction, in the second sentence below, is underlined for emphasis. Dental care providers will find attached replacement page 6 to update their manuals. A vertical line in the left margin marks where text has changed.

Chapter 1 - 10 Periodontics

A gingivectomy for patients who use anticonvulsant medication is a covered service which requires telephone prior authorization. A "gross debridement", code D4355, is available one time per year and may be billed in conjunction with a prophylaxis on the same date of service. ☐

01 - 110 Dental Claim: Current ADA Form Required (1994, 1999 Versions)

As per Bulletin 01 - 44, Dental Claim: Current ADA Form Required (1994, 1999 Versions), issued in April 2001, Medicaid accepts only the current dental claim forms. These are ADA versions 1994 and 1999. Dental claims submitted on forms older than the ADA 1994 version will not be processed. They will be returned to the provider. Requiring current ADA forms facilitates the entry of data into the computer and increases efficiency and cost effectiveness of the claims adjudication process.

Attached are the instructions for the ADA forms. On both sets of forms, the most important field is entering your correct provider identification number. **A dental claim cannot be accepted, nor can payment be made, without a correct provider number.** For ease of use, required fields are marked in the same way for both forms. Please see the instructions. We appreciate your cooperation in using the current ADA forms. ☐

01 - 111 Physical Therapy: Use of an Assistant; Wound Debridement

Use of an assistant for physical therapy has been clarified in SECTION 2 of two Utah Medicaid Provider Manuals: Physical Therapy Services and Physical Therapy and Occupational Therapy Services in Rehabilitation Centers, Chapter 2, Covered Services. [page 6, 7] The first page number in brackets refers to the PT services manual. The second number refers to the corresponding page in the PT & OT services manual.

– All physical therapy services must be performed by a physical therapist or by a physical therapy assistant under the immediate supervision of a physical therapist as defined by Utah Code 58-24a-102. "Immediate supervision" means the supervising physical therapist is:
  (a) present in the area where the person supervised is performing services; and
  (b) immediately available to assist the person being supervised in the services being performed.

  The patient record must be initialed by the physical therapist following the treatment rendered by a physical therapy assistant to certify the treatment was performed under his/her supervision. Physical therapy aids may only provide supplemental care, such as counting repetitions and maintaining exercising form and technique as a coach under the immediate supervision of the supervising physical therapist.
– A new item 3 is added to Chapter 2 [page 6, 7]:
  3. Evaluations are limited to one evaluation per treatment course for a specific condition or diagnosis.
– Chapter 2, item 8, is clarified [page 6, 7]:
  8. Physical therapy treatments are limited to one per day. The evaluation and the first treatment may be billed on the same date of service.

Wound Debridement

Wound debridement is covered if hydrotherapy is used to facilitate the debridement. A simple bandage change is not reimbursable as a physical therapy treatment. This limitation has been added to SECTION 2, Chapter 2 - 2, Limitations [page 8, 9].

Physical Therapy Manuals Updated

Providers will find attached replacement pages to update their manuals. On pages dated October 2001, a vertical line in the left margin marks where text has changed. ☐

01 - 112 Psychologists: DOPL Certification; Intervention Techniques

SECTION 2 of the Utah Medicaid Provider Manual for Psychology Services has been corrected and clarified.

1. Effective July 1, 2001, the Division of Occupational and Professional Licensing (DOPL) requires psychology residents to hold a valid certificate from DOPL in order to provide mental health therapy services. [Chapter 1 - 2, Qualified Psychologists]

2. Medicaid does not cover intervention techniques, commonly referred to as "holding therapy," "rage reduction therapy," or "rebirthing therapy," in which the therapist, or others under the direction of the therapist, physically hold, restrain, or otherwise restrict the physical movement of a child. These services may not be billed to Medicaid. [Chapters 2 - 1, Initial Evaluation, through 2 - 5, Group Therapy]

Providers will find attached SECTION 2 to update their manuals. On pages dated October 2001, a vertical line in the left margin marks where text has changed. ☐

01 - 113 Mental Health Centers and Substance Abuse Providers: Intervention Techniques; Billing for Rural Mental Health Centers

SECTION 2 of the Utah Medicaid Provider Manual for Mental Health Centers and for Substance Abuse Treatment Services has been corrected and clarified.

1. Medicaid does not cover intervention techniques, commonly referred to as "holding therapy," "rage reduction therapy," or "rebirthing therapy," in which the therapist, or others under the direction of the therapist, physically hold, restrain, or otherwise restrict the physical movement of a child. These services may not be billed to Medicaid. [Chapter 2 - 1, Mental Health Evaluation, through 2 - 7, Skills Development Services]

2. The Mental Health Centers Manual now includes procedure codes specific to rural mental health centers. Effective for services provided on or after July 1, 2001, rural mental health centers must use these specific procedure codes in order to be reimbursed under the new fee schedule. [Chapter 2 - 1, Mental Health Evaluation]

Providers will find attached replacement pages for SECTION 2 (pages 1 and 10 - 19) to update their manuals. On pages dated October 2001, a vertical line in the left margin marks where text changed. ☐

01 - 114 Targeted Case Management for the Chronically Mentally Ill and Substance Abuse Services: Billing for Rural Mental Health Centers; Qualified Providers; Modifiers; Other Updates

SECTION 2 of the Utah Medicaid Provider Manual for Targeted Case Management (TCM) for the Chronically Mentally Ill and TCM for Substance Abuse Treatment Services has been corrected and clarified.

1. Effective October 1, 2001, the review requirement for targeted case management service plans has changed. The reviews may be performed every 180 days, rather than every 90 days. [TCM for the Chronically Mentally Ill, Chapter 3 - 1, Required Documentation; TCM for Substance Abuse Treatment Services, Chapter 6, Record Keeping and Required Documentation]

2. Covered and non-covered targeted case management services and activities have been clarified. The following chapters are updated in SECTION 2:
   TCM for the Chronically Mentally Ill, Chapters 2 - 1, Covered Services / Activities, and 2 - 2, Non-covered Services / Activities.
   Substance Abuse Services, Chapter 1 - 2, Scope of Services.
   TCM for Substance Abuse Services, Chapter 5 - 1, Covered Services and Activities, and 5 - 2, Non-covered Services and Activities.

3. Rural mental health centers must use new procedure codes to bill targeted case management services for the chronically mentally ill for dates of service on or after July 1, 2001. The new procedure codes are in Chapter 6, Procedure Codes for Targeted Case Management for The Chronically Mentally Ill.

4. Qualifications have been clarified for individuals who may provide targeted case management for substance abuse services. [Chapter 1 - 4, Qualified Targeted Case Management Providers, and 4 - 4, Qualified Providers]

5. Modifiers for supervising professionals are no longer required. Modifier codes are removed from the TCM manual for the Chronically Mentally Ill, Chapter 6, Procedure Codes.

Providers will find attached SECTION 2 to update their manuals. On pages dated October 2001, a vertical line in the left margin marks where text has changed. ☐

01 - 115 Diagnostic and Rehabilitative Mental Health Services by Department of Human Services Contractors: Intervention Techniques; Subsidized Adoptive Services and Billing

SECTION 2 of the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors (the Medicaid Enhancement Provider Manual) has been corrected and clarified.

1. Medicaid does not cover intervention techniques, commonly referred to as “holding therapy,” “rage reduction therapy,” or “rebirthing therapy,” in which the therapist, or others under the direction of the therapist, physically hold, restrain, or otherwise restrict the physical movement of a child. These services may not be billed to Medicaid. [Chapter 2 - 1, Mental Health Evaluation, through 2 - 9, Family-Based Residential Services]

2. Subsidized Adoptive Children: Services and Billing

   DHS contractors (Medicaid Enhancement providers) may provide mental health services to subsidized adoptive children who are exempt from the Medicaid Prepaid Mental Health Plan (PMHP) for outpatient mental health services. The Medicaid cards for these children will state that outpatient mental health services may be provided by any Medicaid provider. Inpatient psychiatric services must be provided through the designated PMHP contractor.

   SECTION 2, Chapter 1 - 6, is updated to explain billing procedures when providers treat subsidized adoptive children who are exempt from the PMHP. Providers must bill Medicaid directly for services for these children.

   To bill Medicaid for services provided to these children, providers must obtain a new Medicaid provider number and bill Medicaid using established Medicaid billing codes specified in the provider manual. To obtain a new Medicaid provider number, or to discuss questions regarding billing procedures, procedure codes to be used, etc., contact RueDell Sudweeks, Bureau of Managed Health Care, at 538-6636.

Providers will find attached SECTION 2 to update their manuals. On pages dated October 2001, a vertical line in the left margin marks where text has changed. ☐

01 - 116 Targeted Case Management for the Homeless: Qualified Providers; Other Updates

SECTION 2 of the Utah Medicaid Provider Manual for Targeted Case Management for the Homeless has been corrected and clarified.

1. Effective October 1, 2001, the review requirement for targeted case management (TCM) service plans has changed. The reviews may be performed every 180 days, rather than every 90 days. [Chapter 3, Record Keeping]
2. Qualifications of individuals who may provide targeted case management have been clarified. [Chapter 1 - 4, Qualified Providers]
3. Covered and non-covered targeted case management services and activities have been clarified. [Chapter2 - 1, Covered Services, and 2 - 2, Non-covered Services and Activities]
4. Limits for service code Y3115 revised to five hours per patient per inpatient admission. [Chapter 6, Procedure Codes for Targeted Case Management for The Homeless]

Providers will find attached SECTION 2 to update their manuals. On pages dated October 2001, a vertical line in the left margin marks where text has changed. ☐

01 - 117 Nursing Facilities: Case Mix Payment Method

Medicaid will soon begin a new payment method for Medicaid patients in nursing facilities. The new method takes into consideration the "severity" or "case mix" that the provider typically maintains. "Case mix" payment replaces the "one rate fits all" payment method where all providers in the state were paid one basically similar rate for the patient day or per diem, without consideration for the difficulty of the type of patient being maintained.

Medicaid will send a certified letter to providers with the exact implementation date for the case mix payment method. When the method is in place, facilities will be paid according to the following formula:

Facility's Case Mix X State's Benchmark Rate for Case Mix Portion + Non Case Mix Portion = Facility's Daily Payment Rate

Note that the State's rate will be composed of two parts: a case mix portion and a "non case mix" portion. The "benchmark rate" is established by the state to allow the state to stay within budget and still pay facilities, relatively, according to the severity of the patients for whom they provide care.

Each facility will be notified of its case mix calculation as well as the state's benchmark rate. The case mix and the state's benchmark rate will be adjusted quarterly the first year. Notification will be sent of changes. This system has been under development for several months and included the cooperation of all interested providers, the Utah Health Care Association (under the guidance of Joan Gallegos) and the Department of Health. ☐

01 - 118 Client Information and Education

Articles sent to Medicaid clients in the quarterly newsletter "Clientell" are published on the Internet. Copies may be printed and freely distributed for nonprofit, educational purposes. An index of articles is at: www.health.state.ut.us/medicaid/html/clientell_index.htm

Below is a list of "Clientell" articles sent recently to Medicaid clients. If you don't know about the Medicaid newsletter, there is more information at the end of this bulletin.

September 2001

- Work Incentive Program
- Child Car Seat Safety
- Transportation Rules
- Smoking Cessation for Pregnant Women
- Hotline Resources in the Utah Department of Health: Check Your Health, Medicaid Information, Baby Your Baby, CHIP, Immunize by Two, Baby Watch Program, Utah Teen Tobacco Quit Line, Family Dental Plan.

Medicaid Client Newsletter "Clientell"

The "Clientell" is a quarterly publication by the Division of Health Care Financing which is mailed to all households receiving a Medicaid card. The purpose is to educate and inform clients of Medicaid policies, procedures and other issues. It is also a way to share community resources.

The Utah Medicaid population is a very diverse group of people. Our goals are to make information easily understood and to be sensitive to literacy barriers and cultural differences in this population.

We welcome suggestions for articles from providers and other interested parties. The editor of the "Clientell" is Randa Pickle, Consumer Advocate for the Division of Health Care Financing. Please call 1-877-291-5583 or e-mail suggestions to rpickle@doh.state.ut.us. ☐

01 - 119 Emergency Services Program For Non-Citizens: Advising Client of Non-Covered Services

The Emergency Services Program is a health program designed to cover a specific range of emergency services. It has a restricted scope of service for a specific, defined group of individuals. Although the Utah Medicaid agency, the Division of Health Care Financing, administers the program, eligible clients are not entitled to the full scope of Medicaid services.

To make this difference more clear, policy on the Emergency Services Program in SECTION 1 of the Utah Medicaid Provider Manual, has been moved from Chapter 1 - 6 to Chapter 13 - 8 and renamed "Emergency Services Program For Non-Citizens." The on-line version of SECTION 1 is revised to add the policy stated below. [www.health.state.ut.us/medicaid/SECTION1.pdf]

Advising Client of Non-Covered Services

When a service to be rendered to an Emergency Services client is not or does not appear to be emergent in nature, it would be prudent for the provider to inform the patient, prior to the service, that the service will not be covered by Medicaid, that the patient will be financially responsible, and the patient will be billed directly for the service. Compliance with the four conditions for billing a patient for a non-covered service explained in SECTION 1 of the Medicaid Provider Manual, Chapter 6 - 8, would be optional, but advisable, for the provider to follow. ☐

01 - 120 DRG Payment Methodology for Urban Hospitals

Beginning October 1, 2001, Utah Medicaid will begin paying urban hospitals under a revised payment methodology. The new methodology is a result of over two years of discussions and analysis with representatives of the hospital industry. The Utah Hospital and Health Systems Association (UHA) facilitated regular monthly meetings of the task force.

This new payment methodology affects only urban fee-for-service claims. Reimbursement to rural hospitals will continue as in the past. While Medicaid HMOs may choose to make payments based upon this new methodology, they are not required to do so. (HMOs have their own provider agreements). Most fee-for-service claims are for persons who present themselves at a hospital for care and afterwards become eligible for Medicaid to cover the cost of medical services. Once eligible, Medicaid clients are usually enrolled in an HMO for continued Medicaid services.

The new payment methodology includes the following features:

1. New DRG weights based upon recent data.
2. Elimination of the day outlier (everything is paid under a DRG).
3. An outlier payment for charges that exceed 2.5 times the DRG payment.
4. New Medicaid DRGs for selected neonates based upon birth weights.
5. Separate payment adjustments for Graduate Medical Education and Disproportionate Share.
6. Elimination of the current hospital specific factor.

For further information, contact Randy Baker, Associate Actuary, at (801) 538-6733. ☐

01 - 121 Tooele County: Primary Care Case Management, Referrals

Beginning in September, Medicaid cards for some clients in Tooele County will state the client has a Primary Care Physician (PCP). These clients must have a referral from their PCP when seeking care from a specialist. The referring PCP contacts the specialist who notes the verbal referral in the client's chart. The PCP also notes in the client's chart that the referral was made and to whom.

Tooele County Health Department started a Primary Care Case Management program for Medicaid clients living in the Tooele, Grantsville and Stansbury Park areas. The Department met with providers and set up a community base to support the program prior to implementation. The Department will provide information on Medicaid benefits and how to access services. Clients are asked to identify a Primary Care Physician (PCP).

For more information and access to care when a client moves and needs to see a new PCP prior to the change appearing on the Medicaid Card, contact the Tooele County Health Department at 843-2310. ☐